UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH BOARD

WHITE PAPER:
CURRENT AND EMERGING ISSUES IN PUBLIC SUBSTANCE ABUSE AND MENTAL HEALTH

JANUARY 2005

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INTRODUCTION

The Utah State Board of Substance Abuse and Mental Health in the Board meeting in May 2004 commissioned a white paper on current and emerging issues that impact public substance abuse and mental health in Utah. Subsequently, the following individuals met to review the process of developing a white paper that would describe these issues:

Marie Christman, Deputy Director, Utah Department of Human Services

Randall Bachman, Director, Utah Division of Substance Abuse and Mental Health

Rob Johnson, Business Manager, Bear River Mental Health

Dr. James Ashworth, Chairman, Utah Board of Substance Abuse and Mental Health

Jack Tanner, Executive Director, Utah Behavioral Healthcare Network

Patrick Fleming, Director, Salt Lake County Division of Substance Abuse Services

The white paper outlines the background, history, current and emerging issues in substance abuse and mental health. It provides a synopsis of recent history and issues of public substance abuse and mental health services in Utah, and makes recommendations to policymakers for the delivery of future services.

On August 10, 2004, Robin Arnold-Williams, Executive Director of the Utah Department of Human Services, called a meeting of local authority and state officials and other stakeholders to address recent changes in Medicaid policy that have created significant changes in the financing and the services to clients in the public mental health system, as well as clients in other systems. A similar meeting was held on August 24, 2004 to address current issues in substance abuse. Recommendations from both forums are incorporated in this paper.

It is our hope that this white paper will assist everyone concerned about the state of substance abuse and mental health services in Utah by providing information and perspectives that will inform all stakeholders, including elected officials, advocates, government agencies, the non-profit sector, and others who care about the individuals and families we serve.

--Randall W. Bachman, M.Ed., Director, Utah Division of Substance Abuse and Mental Health

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EXECUTIVE SUMMARY

Recent developments in substance abuse and mental health have challenged our ability to maintain the current system of publicly funded services in Utah. From state budget cuts beginning in Fiscal Year 2002, to changes in Medicaid policy that have a fundamental impact on the way mental health services are structured and delivered in the community, dramatic changes have forced a re-examination of our entire system.

The following white paper outlines current and emerging issues and recommendations. It also contains background information on substance abuse, mental health, and Medicaid. From this analysis, and recent meetings to address strategies to address the current challenges in substance abuse and mental health, the following recommendations are offered:

1. Reaffirm Utah's commitment to effective substance abuse and mental health prevention and treatment.
2. Reaffirm that public expenditures for the delivery of effective substance abuse and mental health prevention and treatment services are a wise use of resources.
3. Reaffirm Utah's commitment to the seriously mentally ill and addicted who are indigent and most needy.
4. Support the coordination of funding and services.
5. Increase funding for critical services.
6. Support the goals of the President's New Freedom Commission on Mental Health; including the statement that services must be consumer and family- driven.
7. Engage the primary health care providers.
8. Develop and expand the use of appropriate technology.
9. Support the implementation of effective evidence-based practices based on the best available science.
10. Promote efforts to overcome the stigma of addictions and mental illness.
11. Promote parity in health care for substance abuse and mental health services.
12. Develop a comprehensive statewide plan for the delivery of public substance abuse and mental health services.

It is our hope as the citizens appointed to the Utah Board of Substance Abuse and Mental Health that this white paper will assist everyone who cares about individuals and families with substance abuse and mental disorders in Utah to work together to meet our current challenges and build a life in the community for all who need our assistance.

PART 1

OVERVIEW OF CURRENT AND EMERGING ISSUES AND RECOMMENDATIONS

Since 2001, a downturn in the nation's economy has created significant shortfalls in state budgets. Utah is no exception. Due to these state budget shortfalls and an increase in demand for service, due in part to population increases and an increase in awareness of the need and effectiveness of substance abuse and mental health services, access to and availability of services have been significantly affected. The following synopsis illustrates the impacts in both substance abuse and mental health.

SUBSTANCE ABUSE

On the positive side, there is a growing awareness of the effectiveness of substance abuse prevention and treatment in Utah and throughout the United States. In particular, the impact of substance abuse on the child welfare and justice systems has been well documented. The effectiveness of Drug Courts and similar treatment and intervention programs has been established. Substance abuse prevention programs in Utah are working, as evidenced by a significant reduction in the number of students using alcohol and other drugs in Utah over the last twenty years.

However, an increase in demand for treatment and recent budget cuts has resulted in significant waiting lists. The face of the "typical" substance abuser has changed from a middle-aged male alcoholic to male and female young adults involved in street drugs, particularly methamphetamine, who are also involved in the legal system.

State budget cuts have impacted the access to and the availability of services to those in need of substance abuse treatment. To illustrate, in Fiscal Year 2004 there was:

- A **$75,000** reduction in statewide substance abuse services
- A **$494,400** reduction in funding to local substance abuse centers
- Due to these reductions, the state also stands to lose **$335,000** in federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars due to a Maintenance of Effort failure unless funds are restored or a waiver is granted.

Finally, the **Drug Offender Reform Act (DORA)** is an initiative that is designed eventually to provide assessment and treatment to all who need it in the corrections system. The cost for this initiative will start at **$6.3 million** the first year, **$12.1 million** the second year, and **$17.3 million** at the end of the third year, with the hope to sustain that level of funding on an ongoing basis. While this is a significant investment of state dollars, the proponents project a substantial cost avoidance in slowing the increasing need for prison beds.

MENTAL HEALTH

A positive development, as with substance abuse, is a growing awareness of the effectiveness of appropriate mental health treatment, including early identification and intervention. From the 1999 Surgeon General's Report, to the 2003 President's New Freedom Commission on Mental Health, there is an increased realization, not only in mental health circles, but also among primary health care providers and the general public, about the reality of mental illness and the promise of effective interventions and treatment.

State budget cuts and changes in Medicaid policy have resulted in cuts in service for those in the public mental health system, particularly for those who are uninsured. To illustrate, recent state and federal cuts have resulted in:

- A reduction of **$3,039,400** to the Utah State Hospital. This reduction made it necessary to cut **56** beds, including **26** forensic beds. *(Note: As of this writing, the Division and the State Hospital have been given permission to restore these beds effective December 1, 2004. However, ongoing funding to maintain these beds and to meet the increasing demand of the justice population with mental health issues will continue to be a challenge.)*

- A **$1,262,700** cut in funds to the community mental health centers.

- A **$1,441,300** decrease in funding for state-paid community services, which includes cuts in the Families, Agencies, and Communities Together (FACT) Program.

- Corresponding federal and state funding reductions of **$820,800**, including **$300,000** in state General Fund one-time appropriations, and **$520,800** to community mental health centers and community services.

- Since state and local dollars can be used to match federal Medicaid dollars at a rate of nearly three federal dollars for each state and local dollar, cuts in state and local funding represent a **three-fold loss of Medicaid funds**.

- A pending loss of **$745,000** in federal Mental Health Block Grant funds due to Maintenance of Effort (MOE) failure unless funds are restored or a waiver is granted.

- Recent changes in Medicaid re-basing of rates for the Prepaid Mental Health Plan (Capitation) are projected to impact the budgets of the community mental health centers by a rate reduction of approximately **$3.2 million dollars.** The combined rate reduction and corresponding loss of ability to use Medicaid savings to fund the uninsured result in a loss of approximately **$7 million dollars, a projected caseload reduction of 4,332 clients cut from service, and a reduction of 107 staff positions.** *(For further elaboration, see Parts 3 & 4 of this document.)*

IMPACTS ON BOTH SUBSTANCE ABUSE AND MENTAL HEALTH

The merger of the Division of Substance Abuse and the Division of Mental Health in September 2002 was a significant event. While the rationale was that the merger of the divisions could result in administrative savings, and perhaps a better integration of substance abuse and mental health services, particularly for those with dual diagnoses, advocates for both groups expressed concerns about whether the needs of both target groups would be short-changed. Notwithstanding the merger, there were budget impacts on both systems, including:

- A **$22,000** cut to information technology
- A **$555,900** cut in administration

These cuts impact not only the state's ability to provide technical assistance, training and support; they also increase the difficulty of providing proper oversight. A recent legislative audit raised concerns about the governance of the community mental health centers and the role of the state and local county governments in providing proper oversight.

Overall, the State General Fund cuts to both the substance abuse and mental health systems have been **$7,038,400** since Fiscal Year 2002.

Revenues from all sources for community mental health centers were **$131,527,251** in 2002; revenues for community substance abuse were **$33,566,656**, for a total of **$165,093,907**. *Source: Utah Behavioral Healthcare Network report.* With a projected loss of **$7,000,000** as a result of Medicaid changes, in addition to a **$7,038,400** cut in state funds, and **$520,800** in federal funds, the impact is a loss of **$14,559,200, or an 8.8%** reduction in revenues to the system. Nearly all revenues in the public sector, whether provided by state or local government directly, or contracted to a private non-profit organization, are dedicated to support expenditures for programs and services to eligible target groups. Programs are allowed reasonable administrative costs, and are required to have fund balances to assure program viability in the event of revenue shortfalls or extraordinary client expenditures.

HISTORY OF FUNDING

Mental Health

The following information is from State Profile Highlights from the National Association of State Mental Health Program Directors Research Institute (NRI), June, 2004:

Nearly two-thirds of the funding for public mental health services (63%) was spent for state hospitals in the United States in 1981. By 1993, that trend began to reverse so that only 49% was spent for state hospitals. By 2002, over two-thirds of the funding for public mental health services (67%) was spent on community mental health programs,

and only 30% on state hospitals. Clearly there has been a major change in the way public mental health services have been delivered in the past two decades–from a focus primarily on state hospitals and institutional care to community and family-based treatment approaches. During that same period of time, 1981-2002, state mental health agency controlled spending went from $6.1 billion dollars to $24.9 billion dollars. However, in inflation-adjusted dollars, the increase was from $6.1 billion dollars to $7.2 billion dollars. While the majority of funding (57%) still comes from the state government taxes, most of the recent increase in funding has come from Medicaid.

According to the most recent figures available comparing Utah to other states and the national averages, in Fiscal Year 2002, Utah spent a total of approximately $159 million dollars on public mental health services, which includes state, local, federal block grant and Medicaid expenditures. Of that $159 million, $41 million was spent on the state hospital, and $118 million on community-based mental health.

Utah spent about $69 per person on state controlled mental health services on a per capita basis in Fiscal Year 2002, which includes Medicaid mental health expenditures. The national average was $87. Utah ranked 30th in per capita expenditures. These data are based on expenditures prior to the most recent round of budget reductions.

Funding for state mental health systems is complex. For example, funding for mental health services can come from a variety of payers, including state and local revenues, Medicaid, Medicare, the Health Resources Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA) and its divisions, Housing and Urban Development (HUD), Education, the Social Security Administration, the National Institute of Mental Health (NIMH), and other federal agencies.

Substance Abuse

Unlike mental health, Medicaid and other third party insurance is a small portion of substance abuse funding. The majority of funding for substance abuse prevention and treatment comes from federal and state sources. Local substance abuse authorities are required to match 20% of the state General Fund pass-through dollars for substance abuse. The Substance Abuse Prevention and Treatment (SAPT) Block grant is a major source of federal funding for substance abuse prevention and treatment, currently $17.9 million a year. Twenty percent of the Block Grant must be utilized for prevention services.

Public funding for substance abuse prevention and treatment rose from $22.8 million to $33.6 million from 1997 to 2002. *(Source: UBHN Report: Funding History, Community Mental Health Centers, Local Substance Abuse Programs, 1997-2002).* However, for Fiscal Year 2003, total funding had declined to $32.1 million, and for Fiscal Year 2004, to $30.3 million. The main reason for the decrease was the loss of TOPPS II federal grant money for infrastructure development as well as other federal grants. *(Source:*

DSAMH records).

There has been a marked shift in the "typical" substance abuse treatment client in the last decade. This shift has been from the adult male alcoholic to the adolescent and young adult involved in street drugs, particularly methamphetamine. There has been an increase as well with individuals involved in the criminal justice system or the child welfare system. Consequently, funding for the justice population has increased, through federal grants and tobacco settlement dollars for drug courts. Over the past five years, $8.5 million dollars has been allocated to drug courts and drug boards.

DOLLARS AND SENSE

Studies have demonstrated the wisdom of investing in prevention and treatment of addictions and mental disorders. For example, advocates for Utah's Drug Offender Reform Act (DORA) project a cost offset and avoidance of approximately $5.60 for every dollar spent on treatment for individuals in the criminal justice system based on a study in Oregon: *(Source: Finigan M. "Societal Outcomes of Drug and Alcohol Treatment in the State of Oregon", Oregon Office of Alcohol and Drug Abuse Programs, 1996.)* In prevention, based on a California study, every dollar spent on substance abuse prevention and treatment resulted in a cost avoidance of approximately $7.00. *(Source: CALDATA, California Department of Alcohol and Drug Programs, 1994).*

Dollars spent on effective prevention and treatment in both mental health and substance abuse will help offset costs in:

- Criminal justice
- Law enforcement
- Child protection and child welfare
- Primary health care
- Domestic violence
- Education, including special education
- Unemployment
- And finally, the immeasurable costs of family disruption and instability

IMPACT/STRATEGY MEETINGS

Robin Arnold-Williams, immediate past Executive Director of the Utah Department of Human Services, called state officials, local mental health authorities and their providers, and other stakeholders to an "Impact/Strategy" meeting on August 10, 2004. The purpose of the meeting was to address the current issues in mental health, particularly the impact of Medicaid policy changes on the system. From that meeting, follow up task groups and objectives were developed. The input was synthesized into five overall recommendations:

1. Reassess who is the public client, and review current laws, rules and policies.
2. Reexamine service delivery models to mitigate the impact of reductions on

clients and families.
3. Educate the public and legislature about the impacts of reduced services.
4. Address the funding issues.
5. Promote Collaboration.

Representative task groups have been organized to address each of the areas above, except #5, Promote Collaboration. The recommendation was to use existing forums and affiliations to continue to promote and enhance effective collaboration.

A similar meeting was held on August 24, 2004 to address critical issues in substance abuse, and the following recommendations were made:

Prevention
1. Make prevention a priority.
2. Promote best practices.
3. Address workforce issues.
4. Promote public education.
5. Increase coordination and integration of services.

Treatment
1. Provide adequate funding.
2. Promote best practices.
3. Address workforce issues.
4. Promote integrated treatment.
5. Collaborate with justice programs.

Crosscutting and Other Issues
1. Reduce stigma through public education.
2. Re-design the system to make it more user-friendly.
3. Integrate the categorical funding.
4. Review the infrastructure.
5. Promote local planning.

RECOMMENDATIONS

The State Board of Substance Abuse and Mental Health makes the following recommendations as we move forward to meet the current and future challenges of the system:

1. Reaffirm Utah's commitment to effective substance abuse and mental health prevention and treatment.

More than enough data exist to support the cost-effectiveness of prevention and treatment. Whether in avoiding expenditures in child welfare, health, education, corrections, law enforcement or business, the evidence is irrefutable: *Prevention and treatment work!* We no longer need to "prove it". We need to act on it.

2. Reaffirm that public expenditures for delivery of effective substance abuse and mental health prevention and treatment are a wise use of resources.

Whether it is the fact that every dollar spent on prevention saves seven dollars, or demonstrating the common sense of treatment as an alternative to incarceration, we must continue to promote effective prevention and treatment as a wise investment.

3. Reaffirm Utah's commitment to the seriously mentally ill and addicted who are indigent and most needy.

The current law for mental health requires the system to prioritize services to adults who are seriously and persistently mentally ill and indigent, and children who are seriously emotionally disturbed. In substance abuse, federal requirements determine service priorities, including pregnant drug abusers and women with dependent children. Funding should be aligned to assure those who are most needy are served.

4. Support the coordination of funding and services.

Expenditures for substance abuse and mental health can be found in a variety of public agencies' budgets as well as private insurance, third party payments, client fees and other sources. Identification of possible funding streams and their coordination will assure the cost-effective delivery of services.

5. Increase funding for critical services.

Funding for substance abuse and mental health treatment has not kept pace with demand. Increased funding for critical services should be seen as a wise investment and good public policy.

6. Support the goals of the New Freedom Commission, including the statement that services must be consumer and family driven.

We need to support existing partnerships with consumers and families, and promote new alliances with them. Effective models of consumer involvement have been developed and refined. The system must move toward consumer and family support and engagement. With only one of four or five persons in need of treatment receiving it, we must think outside the professional delivery models and develop and encourage consumer and family directed systems of support.

7. Engage primary health care providers.

Substance abuse and mental health prevention and treatment are public health issues. No longer can primary care physicians, nurses, and other medical professions afford to not address substance abuse and mental illness in their practices. Professionals in the field of substance abuse and mental health must reach out to primary care providers and share their knowledge and expertise in support of the patient.

8. Develop and expand the use of appropriate technology.

Goal six of the New Freedom Commission on Mental Health envisions that technology is used to access mental health care and information, and the same could apply to substance abuse. Not only can technology be used to access care and information, it can be used to creatively connect those in need of care and support, and to help someone manage or recover from his or her disease. Technology could be used in prevention to help families and communities understand the best way to prevent alcohol and other drug abuse, to identify and intervene in the early stages of mental illness, and to promote healthy communities.

9. Support the implementation of effective evidence-based practices based on the best available science.

Professionals must be held to a standard that supports continuous, rigorous, ongoing training and education in the effective delivery of services. Organizations must provide sufficient management and support to assure the delivery of quality services. We should reinforce what works through funding, training, and technical assistance, and abandon approaches that are outdated or ineffective.

10. Promote efforts to overcome the stigma of addictions and mental illness.

Addictions and mental illnesses are some of the most common, yet most treatable illnesses. Stigma hinders the effective intervention, prevention and treatment of these diseases. We must promote the notion that being clean and sober and mentally healthy is essential to overall health, and fight the stereotypes and the prejudices that characterize these illnesses.

11. Promote parity in health care for substance abuse and mental health services.

Addictions and mental illness must be recognized and treated as diseases. Without insurance parity, the primary cost of both illnesses will be borne by the taxpayers.

12. Develop a comprehensive statewide plan for the delivery of public substance abuse and mental health services.

We believe we are currently in a crisis that threatens the infrastructure of our system. However, crisis creates an opportunity to transform and improve the way we do business. Funding to help support the transformation of the public substance abuse and mental health system will be available from the Substance Abuse and Mental Health Services Administration (SAMHSA) in the near future. We should take advantage of that support, and use it as an opportunity to develop a blueprint for what we want the system to be in the future.

CONCLUSION

The recent crisis in substance abuse and mental health funding has presented significant challenges, not only to enhance and expand effective services to those who need them, but also to just maintain and build on what we have. Unfortunately, service cuts in some areas, particularly to those who are uninsured, present a significant risk to public safety and to the well being of our citizens, our communities and our families. New advances in effective prevention, early intervention, and treatment demonstrate that investing in programs that promote healthy lifestyles and provide science-based treatment really do pay dividends in the long run. Utah should use this crisis as an opportunity to not only transform the current system, but also promote and preserve what we have and what we know works.

PART 2

Substance Abuse Services in Utah - 2004

Substance abuse is the misuse, abuse, or dependence on alcohol and other drugs that are both legal and illegal. Abuse and dependence are often not understood to be diseases; however, those who enter treatment for their disease, struggle to overcome and recover from it just like patients with other illnesses. Substance abuse is often thought of as a condition of the "weak-willed" or "immoral", a factor that may cause discrimination and ostracism, both of which impede recovery. Overcoming the social stigma of substance abuse and increasing the public's understanding of treatment and recovery are goals in both Utah and the United States.

Almost 95,000 adults and youth in Utah are in need of treatment for substance abuse, but the current capacity for treatment in the public treatment system is only about 18,000 slots (see chart below). Only 19% who need treatment in Utah receive it.

The best strategy for reducing substance abuse is to prevent it. Prevention research has shown that the longer the onset of substance use is delayed, the lower the chance that a person will develop an addiction. Utah has been a leader in implementing science-based strategies to prevent and delay the use of alcohol and other drugs among youth.

Alcohol has been and still is the most widely abused drug in both the United States and Utah, but both illegal and legal drugs are also used and abused. Methamphetamine is the most common drug of choice among Utah women, which can have devastating impacts on the family and community. Youth are more likely to abuse marijuana, which often leads to harder alcohol and other drugs in later years.

Crime and substance abuse are strongly linked with more than half of all treatment referrals coming from the courts and law enforcement. This takes a toll on those non-offenders who need treatment but are unable to access it because treatment slots are unavailable. Lack of treatment resources for offenders also leads to recidivism and increased costs for both the justice system and community. Substance abuse is one of the major aggravating health care issues in both the United States and in Utah today even though it can be successfully prevented and treated.

Utah Statewide
Need For Treatment Survey Results

District	Adults (18 years +)			Youth (12-17)		
	% Need Treatment	# Need Treatment	Current Capacity	% Need Treatment	# Need Treatment	Current Capacity
Bear River	4.1%	3,747	1,148	5.0%	804	153
Central Utah	5.9%	2,542	449	9.3%	772	78
Davis County	3.3%	5,116	1,121	4.1%	1,158	152
Four Corners	5.7%	1,583	595	15.4%	693	106
Northeastern	7.7%	2,024	239	8.0%	407	68
Salt Lake County	5.7%	35,614	6,949	9.2%	8,354	1,379
San Juan County	4.2%	367	134	3.4%	65	52
Southwest Center	5.1%	4,939	588	7.9%	1,229	125
Summit County-VMH	7.5%	1,565	257	20.5%	618	43
Tooele County-VMH	6.4%	1,695	293	13.1%	585	68
Utah County	4.1%	9,965	1,402	2.5%	1,095	205
Wasatch County	5.4%	541	82	7.4%	127	9
Weber Human Services	5.0%	7,005	2,110	9.9%	2,121	251
Total:	4.9%[a]	76,703	15,367	7.3%[b]	18,028	2,689

a Taken from the 2000 State of Utah Telephone Household Survey Treatment Needs Assessment Project
b Taken from the 2003 State of Utah Prevention Needs Assessment Survey

Understanding Substance Abuse

Biological, medical, psychological, emotional, social, and environmental factors all contribute to substance abuse and dependence. It is a "bio-psycho-social" disorder that is ***progressive, chronic, and relapsing***. Substance abuse often dominates an individual's life with negative impacts both to the individual and to those around him or her (SAMHSA, Changing the Conversation, 2000). As addiction develops and progresses, compulsive use continues regardless of negative consequences experienced by the addict. The ability of an addict to "reason" a way out of addiction and to "will" abstinence becomes more difficult. The compulsion to abuse substances lies partly in the configuration of the human brain. The neocortex provides the individual with the ability to reason and to make complex decisions; however, drugs affect the neocortex in ways that disrupt reasoning and distort judgment. (Daryl S. Inaba, Pharm.D, in "Uppers, Downers, All Arounders").

Strategies Used To Impact Substance Abuse

The two major strategies used to mitigate the impact of substance abuse in the United States are prevention of use/abuse and treatment of addiction. The National Institute for Drug Abuse reports that substance abuse is a preventable behavior and addiction is a treatable disease.

Prevention Science: Delaying Use Reduces Risk of Abuse

Historically, substance abuse prevention has included a vast array of interventions from total prohibition, to temperance, to harm reduction. Currently, skill building, resiliency programs and other science-based strategies are considered the most effective ways to prevent substance abuse. These programs focus on training in self-esteem, developing coping skills and teaching parenting and peer leadership.

The following statistics were collected from patients receiving substance abuse treatment services in Utah in 2003:

1. 36% of patients reported using alcohol or other drugs between the ages of 12 and 15.
2. 42% of clients started using their primary substance of abuse before the age of 16.
3. 59% reported first use occurring before the age of 18.

Prevention research has demonstrated that the longer the onset of alcohol and other drug use is delayed, the lower the chance that a person will begin to use and/or become dependent on that use. Risk and protective factors build on natural resistive strengths that people have, such as supportive friends, family, community, school and church. Researchers Steven Glenn, Ph.D., and Richard Jessor, Ph.D., present four antecedents or predictors of future drug use in children by age 12, that differentiates future abusers from future non-abusers. They are:

1. **A strong sense of family participation and involvement by age 12** - Children who feel that they are significant participants in and valued by their families are less prone to substance abuse in the future.

2. **An established personal position about alcohol, other drugs, and sex by age 12** - Children who have a position on these issues and who can articulate how they arrived at their position, how they will act on it, and what effect their position will have on their lives are less likely to develop alcohol or other drug problems.

3. **A strong spiritual sense and community involvement by age 12** - Young people who feel that they matter, who contribute to their community, and who have a sense of role and purpose in society are less likely to develop significant alcohol or other drug problems.

4. **Attachment to a clean and sober adult role model other than parents by age 12** - Children who can list one or more non-drug using adults for whom they have esteem and to whom they can turn for information or advice are less prone to develop drug abuse problems. These positive role models, often persons like a coach, a teacher, activities leader, minister, relative, neighbor, or family friend, play a critical role in the formative years of a child's development.

Utah, a leader in applying the science of prevention services, has adopted the risk and protective factor model as the basis of its substance abuse prevention services since 1990. Utah also conducts regular Student Health and Risk Prevention Surveys (SHARP) that indicate the level of substance use in the youth population. Lifetime alcohol use among high school students in Utah has decreased from 64% in 1997 to 37% in 2003. Lifetime marijuana decreased from 41% to 19% during the same period, and other drugs (including cigarettes) decreased similarly.

Intervention and Treatment: A Client Focused Model

Treatment of substance abuse in Utah is effective and is based on the best science and practices developed over the last 30 years. Treatment is defined as "the broad range of primary and supportive services—including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services and follow-up, provided for persons with alcohol and/or other drug problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and/or other drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems" (Institute of Medicine, 1990).

The most effective treatment planning is based on an individual's needs and responds to changes in need throughout the stages of treatment. A client focused treatment model comprises these four elements:

1. Screening and assessment to identify treatment needs.

2. Intake, clinical evaluation and placement in an appropriate level of care.

3. Treatment planning, engagement and retention in treatment.

4. Continuing care.

Utah has adopted the American Society of Addictions Medicine's Patient Placement Criteria (ASAM-PPC) as a guideline to place a person in the appropriate level of care/treatment. The severity of substance related disorders varies like other disorders and may range from misuse to addiction, thus, interventions must be matched to the level of severity of the disorder. Simple misuse may require only a brief educational intervention, whereas a diagnosis of substance abuse or dependence may require some level of treatment ranging from outpatient to intensive outpatient (IOP) to partial hospitalization (day treatment) to residential treatment and/or detoxification. Effective treatment addresses multiple factors in preparation for self-management of addiction. The maintenance phase of treatment and recovery is a lifelong process that may or may not require professional treatment services.

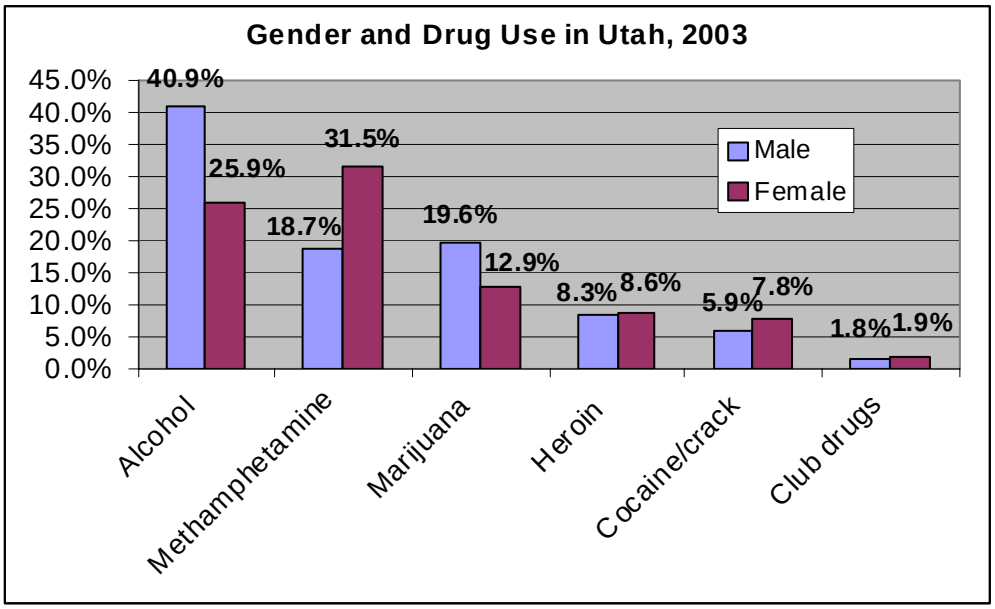
Drugs of Abuse in Utah

In 2003, alcohol was the most commonly abused drug (36.36%) followed by methamphetamine (23.76%). Others included marijuana (17.87%), heroin (8.73%) and cocaine/crack (6.78%). In almost every other state in the nation, marijuana is second to alcohol, which highlights the severity of methamphetamine abuse in Utah. Methamphetamine use moved ahead of marijuana in Utah in 2001 and has continued its upward trend since then.

Currently, males represent two-thirds of the treatment population. In 1991, males represented 82% of the treatment population, and since then the number of women entering treatment has doubled. In 1991, 83% of the admissions in Utah were for alcohol, but in 2003 only 37% of admissions were primarily for alcohol. Treatment for abuse of other drugs has almost tripled in the past 13 years.

Women More Likely to Abuse Drugs Other Than Alcohol

Gender differences in drug use are significant in Utah. The following chart demonstrates that the number of females in treatment exceeds the number of males in only two categories: methamphetamine and cocaine. Heroin and club drug abuse are approximately equal between men and women. The most drastic differences are in alcohol and methamphetamine use. In Utah, men are more likely to abuse alcohol and women are more likely to abuse other drugs. The women who abuse methamphetamines are typically between 18 and 35 and 68% have young, dependent children.



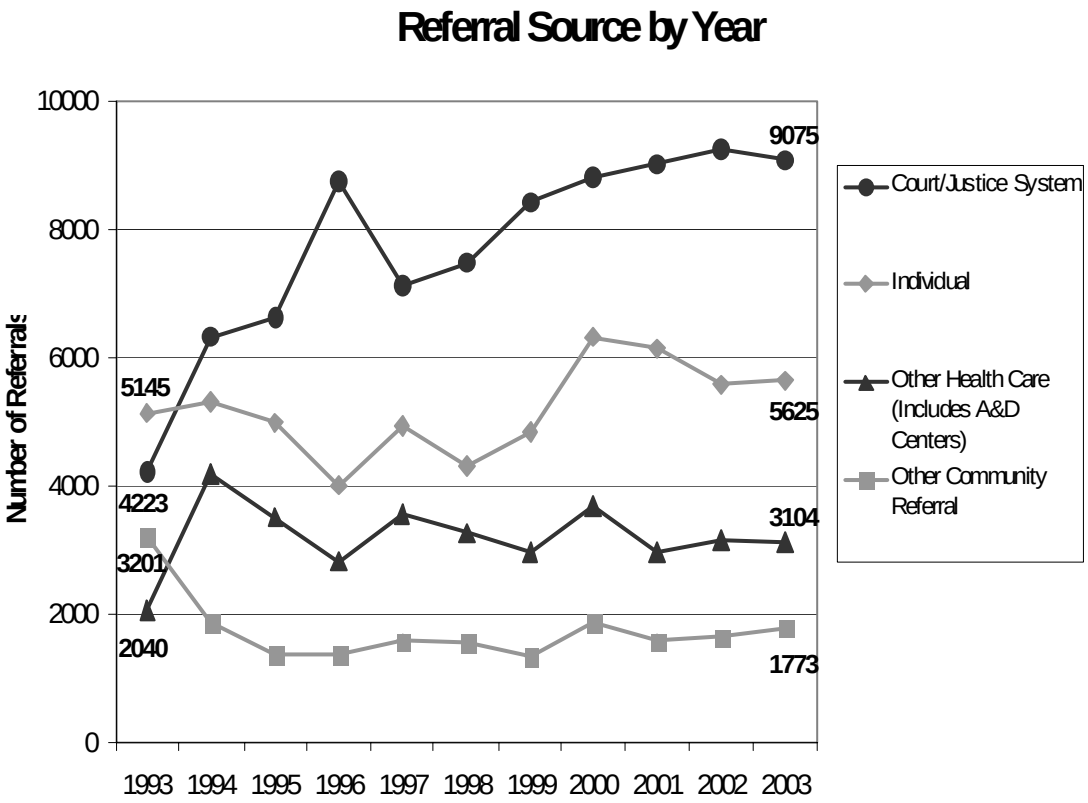
Marijuana is Drug of Choice for Youth

Youth, under the age of 18, are more likely to abuse marijuana than alcohol or any other drug. By maturity, 18–24 years of age, the drugs of choice, almost equally, are alcohol and methamphetamine. Methamphetamine becomes the number one drug of choice for ages 25 to 34. By age 35 and up, alcohol becomes the most commonly abused drug. Prevention and intervention are keys to keeping youth from using and abusing substances.

Treatment System is Dominated by Criminal Justice Patients

The courts and criminal justice system are significant contributors of substance abuse treatment referrals. Since 1994, referrals from the criminal justice system have trended steadily upward, currently reaching more than one-half of all treatment referrals. Utah has concentrated resources and energy on the criminal justice population because of the impact this population has on the community and state. Approximately 70% of prison inmates in Utah have a diagnosable substance abuse problem and would qualify for treatment. Even more are "involved" in alcohol and other drugs, but don't meet the criteria for abuse or dependence.

Referrals also come from individuals (self-referrals), health care providers and other community sources such as employers and religious leaders.



Most Offenders Needing Treatment Don't Receive It

Simply locking up offenders does little to reduce the risk of recidivism so treatment services are provided within the prisons. Ninety-five percent of all inmates are released into their communities upon completion of sentences. The Utah Department of Corrections estimates. However, that only about one-

third of those who need services are able to access treatment. Many of these individuals are among the most chronic users. If the 70% who need substance abuse treatment do not receive it in prison, and if county-based substance abuse treatment resources are not sufficient to meet the need, the adverse impact on their communities is significant. Without readily available community treatment, additional burdens are placed upon courts, county jails, and local law enforcement agencies.

Treatment Works In Utah

Data collection from treatment patients in Utah shows that treatment leads to reduction in use of substances, and often total abstinence. Those completing treatment are able to live independently, stay employed and contribute to their families and communities.

In 2003:

1. 58% of patients completing treatment were abstinent or had decreased use.

2. Homelessness had decreased by 33%.

3. Employment rose by 19%.

4. Criminal activity and arrests were reduced by 69%.

5. Medical visits associated with drug use declined by 50%.

Another Utah study of follow-up data showed that 66% of patients were abstinent after 6 months and employment among them had risen from 37% at admission to 65% at follow-up.

Treatment is Cost Effective

Research on the cost offset for treatment services indicates that for every $1.00 spent on treatment, $7.00 in the costs of crime, healthcare, employment, and social impacts are saved. Investment in substance abuse services keeps families together, keeps people employed, and keeps communities safe. Nationally, substance abuse accounts for over **$**81 billion in associated social, legal, and health related problems. In the criminal justice system, substance abuse increases costs for police and courts and for incarceration and supervision of offenders. Victimization costs of property replacement, medical expenses and insurance premiums are also impacted. Workplace accidents, absenteeism, and healthcare services used are also impacted.

The cost of treatment is much less that the cost of incarceration. An evaluation of the Washington County Drug Court found that it costs 45% less for an offender to participate in drug court for one year than to place an offender in jail

for 90 days. Because many substance abusers are non-violent offenders, community treatment is a viable way to preserve community safety while saving tax dollars. The following estimate shows the cost to incarcerate a female drug abuser with two dependent children.

Treatment Preserves the Family

Perhaps the greatest costs are to families. Children who grow up with adults or older siblings who abuse substances stand a greater chance of becoming abusers themselves. These children may also be neglected, not receiving the appropriate care for their nutritional, educational and nurturing needs.

Incarceration	Treatment
Incarceration for mother = $26,000/year	Treatment services for family = $14,500/year
Foster Care for young child = $35,200/year	
Foster Care for infant = $35,200/year	
Total = $96,400	**Total = $14,500**

Recommendations

1. **Parity in health care insurance for substance abuse services**
   Substance abuse must be recognized and treated as a disease. Until substance abuse treatment is required coverage under health insurance plans it will continue to be funded primarily by taxpayers.

2. **Treatment vs. Incarceration**
   Once community safety is assured, treating substance abusing offenders in community settings saves tax dollars and is more effective. The Drug Offender Reform Act (DORA), considered in the 2004 legislative session and proposed for action in 2005, would accomplish this.

3. **Insist on a science-based approach to prevention and treatment that yields successful outcomes**
   All substance abuse services, whether publicly or privately funded, should be based on proven, science-based approaches that meet or exceed best practice standards and yield the following outcomes:
   1. Abstinence from Alcohol/Other Drug Use.
   2. Increased Employment/Education
   3. Decreased Crime and Criminal Justice Services
   4. Sound Family and Living Conditions

4. **Keep families together, keep people employed, and keep communities safe**
   Healthy families, wherein all of its members are free of alcohol or other drug abuse, are integral to a health society. A healthy society is more productive and more economically stable. Healthy communities and families promote a safer environment and decrease crime.

PART 3

MENTAL HEALTH SERVICES - 2004

Prior to 1992, a traditional fee-for-service model existed in Utah for community-based mental health services. Payment for inpatient care was the responsibility of the state and both inpatient and outpatient services could be provided by any approved provider. This multiple provider model resulted in a fragmented service system with no accountability for outcomes, no flexibility for effective treatment options, no coordinated patient follow-up and no stable housing options for persons with mental illness. The financial risk for the provision of mental health services resided with the payer (the state and federal governments), making cost effectiveness a low priority for providers.

Under the leadership of the Utah State Department of Health and with the involvement and direction of the Governor and Legislature, a new model of service delivery for mental health Medicaid recipients was developed. The new model placed responsibility for all mental health services with a single provider in each established catchment area of the State. It was expected that approaches to services and treatment would be reinvented and any savings occurring would be used as incentives to the provider for developing the capacity and services of the mental health system throughout the state.

Services were reinvented. In 1992, Southwest Center, Valley Mental Health and Four Corners Behavioral Health tested the new model and the "Utah Capitation Experiment" began. Under this new capitated system, these centers were paid a monthly premium for each eligible Medicaid member. All required services were to be provided within the total premium paid. These test centers created annual service data upon which rates were established specific to each center's experience in providing services and treatment. This new model pooled all funding sources together (federal, state and local), integrated and coordinated all client care appropriate to individual client needs, provided a full continuum of care from intensive inpatient to outpatient services, and developed new systems to support treatment including subsidized housing, supported employment, and educational and vocational supports. The model shifted financial risk from the payer to these providers with each center at full risk for any cost overruns. However, financial incentives existed for effective management of costs and for the use of creative solutions by which the need for expensive inpatient care could be reduced. The result was that previous growth rates in state Medicaid expenditures for mental health declined and savings through effective management of care were reinvested to provide expanded treatment program options including services to uninsured/indigent clients with no other funding resources.

The model was expanded to all centers across the State except Northeastern and San Juan Counseling Centers in 1995. Northeastern Counseling changed from fee-for-service to the capitation model in 2001, and later, Heber Valley Counseling was separated from Wasatch Mental Health as a fee-for-service program. Capitated centers were grouped into three categories for the purpose of structuring rates: Rural, Urban

and Valley Mental Health. Rate setting was done by what is now the federal Center for Medicaid Services (CMS) from rates submitted by the Utah Department of Health based upon a review of cost information provided by the capitated mental health centers to the Utah Department of Health. Annual adjustments to Medicaid rates were made to accommodate inflationary factors and program changes. Medicaid revenues also grew in proportion to increases in Medicaid eligibility.

The Federal Balanced Budget Act, effective August 14, 2003, changed the procedures for setting Medicaid rates. Certification of rates by an independent actuary was required. The Utah Department of Health contracted with Pricewaterhouse Coopers for that purpose. To comply, center-specific data was provided to the actuaries for certification. Through these new procedures, rates would now be based on the actual cost of services provided.

The actuaries reported that a comparison of Medicaid revenue to cost, together with elimination of previously eligible services, would reduce Medicaid mental health revenue across the State. The impact of these changes has threatened the continuation of Utah's effective management of care and costs because risk factors would be too great. Medicaid contracts require that all medically necessary services exist in all counties. However, the rates to be provided and the risks associated may affect the ability of some mental health centers to both bear the risk and meet the obligations of the contract in the future. Some mental health centers, if financially unable to bear the risk, may have to abandon the managed care/cost model and revert back to a fee-for-service system with its potential proliferation of high cost treatment placements. Thus, the rule changes by Medicaid, instead of saving money, may have the reverse impact of actually increasing Medicaid costs. The actuaries, concerned about this possibility and to help mitigate the impact of the loss, recommended to the Center for Medicaid Services (CMS) a one-year transitional rate cutting the impact by one/half. No action on this proposal has occurred as of this writing.

These changes will not only adversely impact the mental health systems in many states but will also leave them unable to address recommendations of the Report of the President's New Freedom Commission on Mental Health. Utah will be no exception. Previously, savings accrued through program efficiencies have developed system capacity and services statewide, have provided expanded services to underinsured/indigent clients, have provided continuity of care during periods of client Medicaid disqualification, and have provided client support services keeping them out of more intensive and costly services. That appears no longer possible using Medicaid funds.

<u>The impact on clients who will no longer be able to access services will be tragic. Impacts could be felt in hospital emergency rooms, primary care doctor's offices, jails and juvenile detention facilities, families and mostly the clients themselves, who could be relieved of the consequences of mental illness with treatment. Additionally, the use of Medicaid dollars to subsidize contracts with state agencies (Juvenile Justice Services and Child and Family Services) will no longer be possible.</u>

Medicaid services have been provided for FY 2004 based upon signed contracts, even though rates have not yet been established, and even after the conclusion of the year. The services provided were based on the contractual obligation to provide all medically necessary and appropriate covered services including additional or alternative services (creative interventions) that meet the needs of clients if they are equally effective and result in improved outcomes. Funds provided under the capitation model are expended in providing those services. No funds exist for a retroactive reconciliation even though rates for the year concluded on June 30, 2004 have not yet been established. CMS has been unable to conceptualize its current strategy, to create appropriate reimbursement rates, to reconcile implementation problems, to provide for any meaningful transition and to effectively resolve policy issues with the State. The Mental Health Centers, however, are expected to continue providing services for the next year based upon "good faith relationships" with CMS even though rates for FY 2005 are also not set.

The President's New Freedom Commission on Mental Health produced a superb document calling for a transformation of mental health systems in the nation. Its goals to achieve community living; to provide access to the most current treatments and best support services; to benefit from advances in treatments, support services, research, technology and understanding; and to promote access by clients to accurate information promoting learning, self-monitoring and accountability seems more remote than ever. This is because of the disconnection between these goals and the counter-restrictions of the principal funding source, Medicaid.

<u>The impact of these actions by CMS, coupled in some cases by funding losses due to state funding formula changes, affect different mental health centers in different ways. In anticipation of these impacts, mental health centers have initiated the following actions as cited in actual written communication to clients and agency partners:</u>

1. (Rural) Only clients with Title XIX (Medicaid) eligibility will be served.

2. (Rural) Roles in emergency services to unfunded clients will be limited to funds available.

3. Large numbers of clients will be discharged – As many as a few hundred in some rural mental health centers, many hundreds in some urban centers.

4. (Urban) Cases will either be closed for clients ineligible for Medicaid or they will be referred to other mental health service providers in the community.

5. (Urban) All clients receiving mental health services will be evaluated for Title XIX eligibility.

6. (Urban) Treatment Priority for Uninsured Applicants:
    - Priority #1: Individuals in need of involuntary hospital services and those who are court committed.

- Seriously and Persistently Mentally Ill (SPMI), Seriously Emotionally Disturbed (SED), or Severely Mentally Ill (SMI) individuals who are in acute distress.

7. (Urban) Admission Criteria for Uninsured Applicants:
    - May be treated only to the extent that state dollars are available – no Medicaid dollars may be used.
    - All uninsured individuals requesting services will first complete an application for Medicaid.
    - Applicants admitted to services will first qualify for Medicaid unless they fall within the established treatment priorities.
    - Individuals approved for treatment will receive crisis stabilization services not to exceed 45 days.
    - Those who meet spend-down criteria, and are Medicaid approved, will be treated.

8. (Rural) Each clinic will have a quota for discount fee clients of 12% of total caseload.

9. (Rural) We will no longer be able to serve you with a discounted fee as of June 30.

10. (Rural) If you are receiving medications, primary care physicians may be able to prescribe for you.

11. (Rural) We are no longer allowed to subsidize services to non-Medicaid clients with Medicaid funds.

These changes require new approaches, different service delivery models and organizational structures that will meet the needs of clients and that will help them recover and become resilient as they face the challenges of mental illness.

PART 4:

MEDICAID ISSUES–CURRENT STATUS

The rate certification process has recently concluded, and the net impact on community mental health centers of the rate adjustment process is a reduction of **$3.2 million.** The rate reduction and the corresponding prohibition of using Medicaid savings to fund uninsured clients will have a projected impact of **$7 million** on Utah's community mental health system. We are now required to transfer any savings into a Community Reinvestment Fund that will be administered by state Medicaid. These funds can only be used to benefit the Medicaid client.

Use of Medicaid Revenue on Non-Medicaid Clients – Statements by CMS on this issue clearly indicate that Medicaid funds cannot be used on indigent/uninsured (non-Medicaid) clients that are not Medicaid eligible.

Program Needs and System Capacity Development – Program and system capacity needs that are funded with Medicaid dollars will not be available to non-Medicaid clients. Further, proposals for new development with Medicaid dollars must be provided from a Medicaid Reinvestment Account that would be established from savings in providing Medicaid services (an example might be expanding work related skill development for the chronically mentally ill served by Medicaid). It is possible that Medicaid Reinvestment Accounts would be determined from cost settlements and that all plans for use of the account must be approved by CMS. Two factors should be noted: (1) rules for these accounts do not yet exist, (2) if rates for succeeding years are set on the basis of actual cost of services in the previous year, then for each year that there are savings, the succeeding year's rates would be lowered. If costs were higher, there would be insufficient Medicaid revenue to pay for the services.

Risk – A three percent risk factor will be incorporated into the approved rates that will not be included in calculations for Reinvestment Accounts.

Data Issues – Significant discrepancies still exist between service data provided by the state to the mental health centers upon which services are provided and with that data accepted by actuaries justifying Medicaid costs. Two factors may contribute to this problem: (1) Data system conversions by the state, (2) Changes in eligibility categories for individual clients that occur between the time service is provided and the time compensation for those services occurs due to retroactive eligibility. Other unknown factors may also exist.

It should also be noted that problems with the capacity, quality, and collection of data on a local level by the Community Mental Health Centers has been a factor as well.

Transitional Rate - Conflicting messages on the likelihood of a blended/transitional rate have been received, one from the CMS Regional Office, the other from the national office.

Finally, it should be noted that there is still uncertainty regarding the final implications of the decisions made at the federal level at the Center for Medicaid and Medicare services and the Office of Management and Budget.

PART 5

LANDMARKS IN MENTAL HEALTH AND SUBSTANCE ABUSE

LANDMARKS IN PUBLIC MENTAL HEALTH:

In recent years there have been two major landmark reports on public mental health, the 1999 Surgeon General's Report, and the 2003 Report on the President's New Freedom Commission:

Mental Health: A Report of the Surgeon General

In 1999, David Satcher, M.D., Ph.D., the Surgeon General of the United States, issued a report on Mental Health. This report emphasized that mental health and physical health are inseparable, and that we must move from the stigma associated with mental illness and addictions to viewing these afflictions in the same light that we view physical illnesses.

The report outlined a vision for the future, which included a commitment to:

- Continue to build the science base
- Overcome stigma
- Improve public awareness of effective treatment
- Ensure the supply of mental health services and providers
- Ensure the delivery of state of the art treatments
- Tailor treatment to age, gender, race and culture
- Facilitate entry into treatment, and
- Reduce financial barriers to treatment

The President's New Freedom Commission on Mental Health

In April 2002, President George W. Bush announced the creation of the New Freedom Commission on Mental Health, stating: "Our country must make a commitment. Americans with mental illness deserve our understanding and they deserve excellent care." The commission was charged with the responsibility to make recommendations that would enable individuals with mental illness to live, work, learn and participate fully in their communities. It rejected a piecemeal approach to mental health reform, and instead issued recommendations to fundamentally transform the Nation's approach to mental health care. Thus, the report that was released in July 2003 was entitled: *Achieving the Promise: Transforming Mental Health Care in America.* This transformation is captured in the Vision Statement:

"We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports–essentials for living, working, learning, and participating fully in the community."

The Commission proposed six broad goals in a transformed system:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

In Utah, the belief was that same compelling vision and the goals stated to transform the mental health system could be applied to substance abuse as well.

LANDMARKS IN SUBSTANCE ABUSE

LANDMARKS IN SUBSTANCE ABUSE PREVENTION

Early 1980's:	Began development of Utah's K-12 Alcohol, Tobacco and Other Drug Prevention Education Program, a scoped and sequenced curriculum for students in kindergarten through high school (later named "Prevention Dimensions"). Program is a partnership between the Utah State Office of Education, Division of Substance Abuse and Mental Health, and Department of Health, along with local school districts, substance abuse authority agencies, and health departments.
1983:	Utah Legislature passed beer tax increase. $2 million of new tax revenue was appropriated to the Division for the establishment of school- and community-based prevention programs, including teacher in-service training for the K-12 Program.
1983:	Establishment of a statewide network of Substance Abuse Prevention Specialists with new revenue from beer tax.

1983:	Governor Scott Matheson created the Governor's Youth Council (GYC – now the *Governing* Youth Council) to provide a meaningful way for youth to be involved in combating substance use/abuse among their peers. The Division supported the GYC for years; it now has a multi-agency support structure, involving several state departments and agencies (DSAMH, CCJJ, Public Safety/Highway Safety Office, Education, Health, Utah Council for Crime Prevention).
1985:	Utah Federation for Drug-Free Youth (UFDY) established. Provided a means for parents, volunteers, and others to become involved in substance abuse prevention.
1985:	Established a full-time position for a Substance Abuse Education Specialist at the Utah State Office of Education.
1986:	Federal Drug-Free Schools and Communities Act enacted by Congress and signed into law by President Ronald Reagan.
1987:	Utah receives first year appropriation of federal Drug-Free Schools and Communities Act funding. Eighty percent (80%) is appropriated to the Utah State Office of Education, 90 percent of which is allocated to Utah's 40 school districts. Twenty percent (20%) is appropriated to the Governor's Office for programs targeted at high-risk youth.
1989 or 1990:	Federal Block Grant requirement of 20% set-aside for prevention enacted.
1990:	Utah Legislature created the Utah Substance Abuse Coordinating Council (in 1994 added an anti-violence component and was renamed the Utah Substance Abuse and Anti-Violence Coordinating Council/USAAV). The Council included a Prevention Subcommittee.
1993:	Risk and Protective Factor Model of Substance Abuse Prevention adopted by the Utah State Board of Substance.
1997 to Present:	Utah participation in several multi-state consortium projects with the Center for Substance Abuse Prevention (CSAP), National Institute on Drug Abuse (NIDA), and the University of Washington Social Development Research Group (SDRG) to test the Risk and Protective Factor framework.
2000:	CSAP awarded a State Incentive Cooperative Agreement (SICA/SIG) to Utah. Award was for $2.9 million per year for three years (total of $8.7 million). Purpose was to implement science-based prevention programs targeting 12-17 year olds.

2002: Merger of DSA + DMH = DSAMH

2003: DSAMH began development of a "Pro-Vention" Model for promoting mental health, based upon successful substance abuse prevention models.

2003 CSAP awarded a State Incentive Enhancement Grant (SIG-E) to Utah. Award was for $750,000 per year for three years (total of $2,250,000). Purpose is to implement extend the SICA model (science-based prevention programs) to 18-25 year old college students.

NATIONAL LANDMARKS IN SUBSTANCE ABUSE TREATMENT

1. Adoption of National Institute of Drug Abuse (NIDA) Principles of Effective Treatment (1999)

The Principles of Effective Treatment highlight the need to replace program-driven treatment with client-driven treatment; tailor length of stay to address individual clinical needs rather than fit persons with varying needs to a prescribed length of stay; manage an individual's care throughout an entire continuum of services and menu of services; improve performance monitoring and outcome analysis and promote scientific proven treatment services.

2. Access to Recovery (2003)

President George W. Bush announced in his State of the Union Address in January 2003, a new substance abuse treatment initiative, Access to Recovery (ATR). The purpose of ATR is to increase consumer choice, including faith-based programmatic options, increase treatment capacity and allow clients to access a comprehensive array of clinical treatment and recovery support services through the use of vouchers to pay for a range of effective, community-based substance abuse services. ATR is outcome-oriented and supports "best practice" models. In the fall of 2004, $100 million dollars was distributed to 14 states and one tribal organization in three-year grants.

UTAH LANDMARKS

1. Adoption of ASI and ASAM (2001)

DSAMH requires the use of the Addiction Severity Index (ASI) as a common assessment instrument, which provides consistent information for each adult client entering treatment with local authorities. The required use of the American Society of Addiction Medicine (ASAM) Uniform Patient Placement Criteria Second Edition-Revised

has resulted in more effective and appropriate treatment placements and has reduced length of stays in more costly services. The adoption of these tools places emphasis on client-driven treatment rather than program-driven treatment and on variable lengths of services rather than fixed length.

2. Completion of Substance Abuse Treatment Practice Guidelines (2003)

DSAMH staff and representatives from local substance abuse providers developed these guidelines. The practice guidelines are based on the most recent scientific and clinical knowledge available from the literature and from outcome research.

NATIONAL LANDMARKS IN SUBSTANCE ABUSE TREATMENT OF THE JUSTICE POPULATION

1. Explosion in Illicit Drug Use

The segment of society using drugs between 1950 and 1970 expanded with the crack cocaine epidemic of the mid-1980's, and the number of drug arrests skyrocketed. Initial legislation redefined criminal codes and escalated penalties for drug possession and sales. These actions did little to curtail the illicit use of drugs and alcohol. As law enforcers redoubled their efforts, America's prisons were filled, compromising Federal and State correction systems' abilities to house violent and career felons. Some States scrambled to "build out" of the problem, spending hundreds of millions of dollars on new prisons, only to find that they could not afford to operate or maintain them.

2. The Nation’s First Drug Court established in Miami in 1989.

The first drug court was implemented in 1989 in Miami, Florida when Judge Herbert M. Klein, troubled by the disabling effects that drug offenses were wreaking upon Dade County courts, became determined to "solve the problem of larger numbers of people on drugs." The court became a model program for the Nation.

UTAH LANDMARKS

1. Dramatic increase in the number of individuals referred from the criminal justice system

The number of referrals to Utah’s public substance abuse programs from the criminal justice system has risen dramatically over the past 10 years, from 5145 to 9075, nearly 1/2 of the 19,577 referrals to the system. At the same time, the number of inmates who need substance abuse treatment services has also risen to 70% of all incarcerated state prisoners.

2. In 2001, methamphetamine became the primary illicit drug of choice

After alcohol (36.36%), methamphetamine is the most commonly abused drug among Utahans who entered treatment in 2003 (23.76%). Methamphetamine was followed by marijuana (17.87%), heroin (8.73%) and cocaine/crack (6.78%). In almost every other

state in the nation, marijuana is the highest drug after alcohol, which highlights Utah's problem with meth. Methamphetamine surpassed marijuana in Utah by 2001, and has continued an upward trend since then.

Methamphetamine continues to be the drug of choice among Utah women of childbearing age who use and abuse illegal drugs. Of particular concern is the fact that two-thirds (68%) of these women have young, dependent children. It is estimated that about 70% of males and 81% of females are at risk of abuse or dependence on alcohol or drugs upon entering the Salt Lake County Metro Jail (2002). In addition, 58% of males and 74% of females test positive for an illicit drug at the time of arrest. This does not include alcohol intoxication (ADAM, 2002).

3. Utah's First Drug Court Established in 1996

In 1996, the first Drug Court in Utah was established in Third District Court (Salt Lake). Designed as an alternative for non-violent drug offenders, it provides intensive drug treatment and monitoring as opposed to traditional sentencing and incarceration. During 1997, Third District's Drug Court has begun to see the fruits of its labor with the first graduates of the program. According to the U. S. Department of Justice, the recidivism rate of drug offenders sent to prison can be more than 60% with recidivism among drug court participants ranging from 5% to 28%.

4. Tobacco Settlement Funding for Utah's Drug Courts

This new law, effective in 2000, expanded existing drug court programs and created the criteria for participation in drug court programs**.** In total, $1,646,867 million dollars of Tobacco Settlement funds were used to create a statewide Drug Court and Drug Board program. Sixteen drug courts and 2 drug boards are funded through this program**.**

5. 2000, creation of the Collaborative Interventions for Addicted Offenders (CIAO) Program

CIAO program was created in 2000 to address substance abuse among parolees and probationers in Utah. This program provides a continuum of evidence based treatment services in the community. CIAO is the result of a partnership between the Division of Substance Abuse and Mental Health and the Utah Department of Corrections. CIAO is funded with $755,000 of Federal Substance Abuse Block Grant funds.

(Ms:dsamh: white paper final 1.22.05jrb)